Today's Date_____

First Name	MI	Last Name	Sex	Birthdate	Age

Home Address	City	State	Zip	Home Phone	Cell Phone	Text OK? []

Occupation / Employer	Referred By	Preferred e-mail address

Reason for today's visit / Chief complaint: _____

Year of last eye examination: _____ Where seen: _____Last eye dilation: _____

Please list any current or past eye conditions, medications, trauma or surgeries, with approximate dates:_____

_____

List any family eye conditions, and their relationship to you:_____

Circle any systemic disorders (please explain below) Allergic Cardiovascular Fever/Fatigue/Weight loss Ear-Nose-Throat Endocrine Gastrointestinal Genitourinary Blood/Lymphatic Immunologic Skin Musculoskeletal Neurologic Psychiatric Respiratory

_____

Name/location of your primary physician:_____Year of last exam:_____

List your current medications, with start date (year): _____

_____

Do you have medication allergies? [] No known allergies [] Yes Please list: _____

Contact lens wearers please fill out the following information:

Which type of contact lenses do you wear? _____Average number of days per week wearing contacts: _____

Average wearing time per day (in hours): _____Contact lens solution brand: _____

If disposable lenses, frequency of disposal: _____Age of current pair of contact lenses:_____

How many years have you worn contact lenses?_____Any current problems with lens wear?_____

Check if you currently or in the past have had any of the following symptoms, and when:

	Yes	No	When	Office use only
Migraine headaches	[]	[]	_____	G43.109 V
Floaters in vision	[]	[]	_____	H43.393 P
Flashes in vision	[]	[]	_____	H53.19 V
Glare sensitivity	[]	[]	_____	H53.71 V
Eye strain	[]	[]	_____	H53.143 V
Light sensitivity	[]	[]	_____	H53.19 V
Double vision	[]	[]	_____	H53.2 V
Routine headaches	[]	[]	_____	--

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Christopher P. Young, OD Inc. _____

If signing as a personal representative, describe relationship to the patient and the source of authority to sign this form: Signature Date